FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036533

Facility Name: Willow Crest Nursing Pavilion

Address: 515 North Main (Number) Sandwich (City) 60548 (Zip Code)

County: Dekalb

Telephone Number: (815) 786-8426 **Fax #** (815) 786-6487

HFS ID Number: 363718794001

Date of Initial License for Current Owners: 01/11/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Richard S. Sgarlata, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	58	Skilled (SNF)	58	21,170	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	116	TOTALS	116	42,340	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,915	2,573	6,024	10,512	8
9	SNF/PED					9
10	ICF	13,893	4,341	58	18,292	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,808	6,914	6,082	28,804	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.03%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/1/90

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/90 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 5,868

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	184,570	17,927	7,824	210,321		210,321		210,321			1
2	Food Purchase		149,586		149,586	(19,163)	130,424	(416)	130,007			2
3	Housekeeping	46,001	13,455	46,980	106,436		106,436		106,436			3
4	Laundry	28,322	13,845	31,320	73,487		73,487		73,487			4
5	Heat and Other Utilities			105,625	105,625		105,625	768	106,393			5
6	Maintenance	75,160	48,938	47,361	171,459		171,459	6,049	177,508			6
7	Other (specify):*							418	418			7
8	**TOTAL General Services**	334,053	243,751	239,110	816,914	(19,163)	797,752	6,819	804,570			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,367,904	40,412	18,304	1,426,620		1,426,620	(1,991)	1,424,629			10
10a	Therapy		1,132		1,132		1,132		1,132			10a
11	Activities	59,263	6,080	3,072	68,415		68,415		68,415			11
12	Social Services	43,625		2,530	46,155		46,155		46,155			12
13	CNA Training			575	575		575		575			13
14	Program Transportation			432	432		432		432			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,470,792	47,624	26,113	1,544,529		1,544,529	(1,991)	1,542,538			16
	C. General Administration											
17	Administrative	81,225		41,000	122,225		122,225	38,475	160,700			17
18	Directors Fees											18
19	Professional Services			335,450	335,450	(4,310)	331,140	(246,801)	84,339			19
20	Dues, Fees, Subscriptions & Promotions			72,613	72,613		72,613	(62,414)	10,199			20
21	Clerical & General Office Expenses	18,255	3,940	37,156	59,351		59,351	27,247	86,598			21
22	Employee Benefits & Payroll Taxes			289,036	289,036	19,163	308,199	(934)	307,265			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,585	1,585		1,585	64	1,649			24
25	Other Admin. Staff Transportation			149	149		149	1,023	1,172			25
26	Insurance-Prop.Liab.Malpractice			61,473	61,473		61,473	1,299	62,772			26
27	Other (specify):*							23,369	23,369			27
28	**TOTAL General Administration**	99,480	3,940	838,462	941,882	14,853	956,735	(218,672)	738,063			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,904,325	295,315	1,103,685	3,303,325	(4,310)	3,299,015	(213,844)	3,085,171			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Willow Crest Nursing Pavilion #0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			124,151	124,151		124,151	113,909	238,060			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,288	10,288		10,288	89,954	100,242			32
33	Real Estate Taxes			39,604	39,604	4,310	43,914	2,057	45,971			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			2,580	2,580		2,580	3,433	6,013			35
36	Other (specify):*											36
37	**TOTAL Ownership**			656,623	656,623	4,310	660,933	(270,647)	390,286			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	147,099	200,417	2,130	349,646		349,646	(491)	349,155			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,510	63,510		63,510		63,510			42
43	Other (specify):*	20,512			20,512		20,512	(20,512)				43
44	**TOTAL Special Cost Centers**	167,611	200,417	65,640	433,668		433,668	(21,003)	412,665			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,071,936	495,732	1,825,948	4,393,616		4,393,616	(505,494)	3,888,122			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	15,924	30		9
10	Interest and Other Investment Income	(4,656)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(357)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(674)	21		24
25	Fund Raising, Advertising and Promotional	(60,145)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,507)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(38,364)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (91,779)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(413,715)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (413,715)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (505,494)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Willow Crest Nursing Pavilion

ID# 0036533

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Discounts Earned	$ (491)	21	1
2	Bank Charges	(29)	21	2
3	Office Expense - PPA	(4,896)	21	3
4	Nursing Supplies - PPA	(538)	10	4
5	Ancillary Supplies - PPA	(241)	39	5
6	Employee Benefits- PPA	(934)	22	6
7	Repairs & Maintenance - PPA	(437)	06	7
8	Food - PPA	(59)	02	8
9	Marketing Salary	(20,512)	43	9
10	COPE Dues	(1,855)	20	10
11	Franchise Tax - Bldg. Co.	(250)	21	11
12	State Replacement Tax - Bldg. Co.	(3,872)	21	12
13	Accounting Fees - Bldg. Co.	(900)	19	13
14	Amortization Mtg. Cost - Bldg. Co.	(1,350)	36	14
15				15
16				16
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20				20
21				21
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100				100
101	**Total**	(38,364)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(416)											(416)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			768									768	5
6	Maintenance	(437)		2,187	4,299								6,049	6
7	Other (specify):*					418							418	7
8	**TOTAL General Services**	(853)		2,955	4,299	418							6,819	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(538)					(1,453)						(1,991)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(538)					(1,453)						(1,991)	16
	C. General Administration													
17	Administrative			(41,000)	79,475								38,475	17
18	Directors Fees													18
19	Professional Services	(900)	900	(246,801)									(246,801)	19
20	Fees, Subscriptions & Promotions	(63,000)		586									(62,414)	20
21	Clerical & General Office Expenses	(12,719)	4,122	31,115	4,729								27,247	21
22	Employee Benefits & Payroll Taxes	(934)											(934)	22
23	Inservice Training & Education													23
24	Travel and Seminar			64									64	24
25	Other Admin. Staff Transportation			1,023									1,023	25
26	Insurance-Prop.Liab.Malpractice			1,299									1,299	26
27	Other (specify):*			6,426		16,943							23,369	27
28	**TOTAL General Administration**	(77,553)	5,022	(247,288)	84,204	16,943							(218,672)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(78,944)	5,022	(244,333)	88,503	17,361	(1,453)						(213,844)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Willow Crest Nursing Pavilion** **#** **0036533** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**(to Sch V, col.7)**	
30	Depreciation	**15,924**	**96,267**	**1,718**									**113,909**	**30**
31	Amortization of Pre-Op. & Org.													**31**
32	Interest	**(4,656)**	**92,689**	**1,921**									**89,954**	**32**
33	Real Estate Taxes			**2,057**									**2,057**	**33**
34	Rent-Facility & Grounds		**(480,000)**										**(480,000)**	**34**
35	Rent-Equipment & Vehicles			**3,433**									**3,433**	**35**
36	Other (specify):*	**(3,350)**	**3,350**											**36**
37	**TOTAL Ownership**	**7,918**	**(287,694)**	**9,129**									**(270,647)**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													**38**
39	Ancillary Service Centers	**(241)**					**(250)**						**(491)**	**39**
40	Barber and Beauty Shops													**40**
41	Coffee and Gift Shops													**41**
42	Provider Participation Fee													**42**
43	Other (specify):*	**(20,512)**											**(20,512)**	**43**
44	**TOTAL Special Cost Centers**	**(20,753)**					**(250)**						**(21,003)**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(91,779)**	**(282,672)**	**(235,204)**	**88,503**	**17,361**	**(1,703)**						**(505,494)**	**45**

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 480,000			$	$ (480,000)	1
2	V	32	Interest Income	1,141				(1,141)	2
3	V	32	Interest Expense- Chase				93,830	93,830	3
4	V	21	Franchise Tax				250	250	4
5	V	21	State Replacement Tax				3,872	3,872	5
6	V	19	Accounting Fees				900	900	6
7	V	30	Depreciation Expense				96,267	96,267	7
8	V	36	Amoritization - Mortgage Costs				3,350	3,350	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 481,141			$ 198,469	$ * (282,672)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 768	$ 768	15
16	V	6	REPAIRS & MAINT.				2,187	2,187	16
17	V	19	PROFESSIONAL FEES				1,599	1,599	17
18	V	20	DUES AND SUBSCRIPTIONS				586	586	18
19	V	21	CLERICAL & GENERAL				31,115	31,115	19
20	V	24	SEMINARS AND TRAVEL				64	64	20
21	V	25	AUTO EXP.				1,023	1,023	21
22	V	26	INSURANCE				1,299	1,299	22
23	V	27	EMP.BEN. - GEN. ADMIN.				6,426	6,426	23
24	V	30	DEPRECIATION				1,718	1,718	24
25	V	32	INTEREST				1,921	1,921	25
26	V	33	REAL ESTATE TAXES				2,057	2,057	26
27	V	35	EQUIPMENT RENTAL				3,433	3,433	27
28	V								28
29	V	17	MANAGEMENT FEES	41,000				(41,000)	29
30	V	19	BOOKKEEPING SERVICES	248,400				(248,400)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 289,400			$ 54,196	$ * (235,204)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 4,299	$ 4,299	15
16	V		17	ADMIN. CMP. - M. MAUER				11,858	11,858	16
17	V		17	ADMIN. CMP. - M. AARON				13,260	13,260	17
18	V		17	ADMIN. CMP. - F. AARON				14,122	14,122	18
19	V		17	ADMIN. CMP. - S. GOLDSTEIN						19
20	V		17	ADMIN. CMP. - S. KOPLIN				7,726	7,726	20
21	V		17	ADMIN. CMP. - D. MAGAFAS				8,162	8,162	21
22	V		17	ADMIN. CMP. - S. LEVY				11,037	11,037	22
23	V		17	ADMIN. CMP. - HOWARD ALTER						23
24	V		17	ADMIN. CMP. - NON-OWNER				13,310	13,310	24
25	V		21	CLERICAL CMP. - S. AARON				4,729	4,729	25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 88,503	$ * 88,503	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 418	$ 418	15
16	V		27	EMP. BEN.- M. MAUER				811	811	16
17	V		27	EMP. BEN.- M. AARON				1,055	1,055	17
18	V		27	EMP. BEN.- F. AARON				6,749	6,749	18
19	V		27	EMP. BEN.- S. GOLDSTEIN						19
20	V		27	EMP. BEN.- S. KOPLIN				2,705	2,705	20
21	V		27	EMP. BEN.- D. MAGAFAS				661	661	21
22	V		27	EMP. BEN.- S. LEVY				1,730	1,730	22
23	V		27	EMP. BEN.- HOWARD ALTER						23
24	V		27	EMP. BEN.- NON-OWNER				2,184	2,184	24
25	V		27	EMP. BEN. - S. AARON				1,048	1,048	25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 17,361	$ * 17,361	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V	10	MEDICAL SUPPLIES	4,983	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	3,530	(1,453)	16
17	V	39	ANCILLARY EXPENSE	857	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	607	(250)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 5,840			$ 4,137	$ * (1,703)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Sharon Aaron	Owner	Clerical	0.56%	see attached	2.79	6.98%	Dynamic	$ 4,729	21-07	1
2	Fred Aaron	Owner	Administrative	13.10%	see attached	7.50	15.96%	Dynamic	31,122	17-01,17-07	2
3	Maurice Aaron	Owner	Administrative	23.79%	see attached	3.12	6.24%	Dynamic	13,260	17-07	3
4	Marshall Mauer	Owner	Administrative	10.78%	see attached	2.79	5.58%	Dynamic	11,858	17-07	4
5	Sue Koplin	Owner	Administrative	0.56%	see attached	4.26	10.65%	Dynamic	7,726	17-07	5
6	Dennis Nehmer	Owner	Maintenance	0.56%	see attached	3.12	7.80%	Dynamic	4,299	6-07	6
7	Diania Magafas	Owner	Administrative	0.56%	see attached	3.51	7.80%	Dynamic	9,162	17-01,17-07	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 82,156		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	413,836	12	$ 11,039	$	28,804	$ 768	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	413,836	12	31,419		28,804	2,187	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	413,836	12	22,969		28,804	1,599	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	413,836	12	8,420		28,804	586	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	413,836	12	447,045	345,326	28,804	31,115	5
6	24	SEMINARS AND TRAVEL	PATIENT DAYS	413,836	12	917		28,804	64	6
7	25	AUTO EXP.	PATIENT DAYS	413,836	12	14,696		28,804	1,023	7
8	26	INSURANCE	PATIENT DAYS	413,836	12	18,661		28,804	1,299	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	413,836	12	92,321		28,804	6,426	9
10	30	DEPRECIATION	PATIENT DAYS	413,836	12	24,690		28,804	1,718	10
11	32	INTEREST	PATIENT DAYS	413,836	12	27,602		28,804	1,921	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	413,836	12	29,555		28,804	2,057	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	413,836	12	49,319		28,804	3,433	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 778,653	$ 345,326		$ 54,196	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	9	55,120	55,120	3	4,299	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	170,000	170,000	3	11,858	2
3	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	170,000	170,000	3	13,260	3
4	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	47	6	88,500	88,500	8	14,122	4
5	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	24,000	24,000			5
6	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	40	7	72,485	72,485	4	7,726	6
7	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	9	104,642	104,642	4	8,162	7
8	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	45	11	158,233	158,233	3	11,037	8
9	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000	12,000			9
10	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	9	170,636	170,636	4	13,310	10
11	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	11	67,785	67,785	3	4,729	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,093,401	$ 1,093,399		$ 88,503	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	9	5,362		3	418	1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	11,631		3	811	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	13,532		3	1,055	3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	47	6	42,295		8	6,749	4
5	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	45	3	33,649				5
6	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	40	7	25,376		4	2,705	6
7	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45	9	8,470		4	661	7
8	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	45	11	24,807		3	1,730	8
9	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,105				9
10	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	9	27,997		4	2,184	10
11	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	11	15,016		3	1,048	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 209,240	$		$ 17,361	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LINCOLN MEDICAL SUPPLIES, INC.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						3,530	2
3	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						607	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 4,137	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Ford Credit		X	Van			$	$ 37,880			$ 2,640	1
2	Chase		X	Mortgage			3,350,000	1,258,156			93,830	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Chase		X	Line of Credit				63,333			5,860	6
7	Allocation from Dynamic		X								1,921	7
8	See Supplemental Schedule										1,788	8
9	TOTAL Facility Related						$ 3,350,000	$ 1,359,369			$ 106,039	9
	B. Non-Facility Related*											
10	Interest Income										(4,656)	10
11	Interest Income (Bldg. Co)										(1,141)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (5,797)	14
15	TOTALS (line 9+line14)						$ 3,350,000	$ 1,359,369			$ 100,242	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Insurance Financing		X				$	$			$ 1,788	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										1,788	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Willow Crest Nursing Pavilion **#** 0036533 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	61,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	51,661	2
3. Under or (over) accrual (line 2 minus line 1).	$	(9,339)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	51,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	4,310	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	45,971	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	50,345	8
	2001	52,352	9
	2002	60,439	10
	2003	59,388	11
	2004	49,604	12

2005 Accrual = 2004 Tax $49,604 x 1.03= $51,092 (rounded)

Alloc Dynamic - $2,057

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Willow Crest Nursing Pavilion COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0036533

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-26-433-024	Long Term Care Property	$ 49,603.88	$ 49,603.88
2.	See Attached	Home Office Allocation	$ 29,908.15	$ 2,081.68
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 79,512.03	$ 51,685.56

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Willow Crest Nursing Pavilion COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0036533

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,430 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facillity		1998	$ 327,859	1
2					2
3	TOTALS			$ 327,859	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1990	21,410		20	1,071	1,071	16,597	9
10	Various			1991	9,997		20			9,918	10
11	Various			1992	4,279		20	214	214	2,898	11
12	Various			1993	26,868		20	1,344	1,344	16,629	12
13	Various			1994	8,312		20	416	416	4,798	13
14	Various			1995	3,234		20	162	162	1,706	14
15	Various			1996	17,411		20	870	870	7,980	15
16	Various			1997	68,499		20	3,425	3,425	27,517	16
17	Various			1998	31,645		20	1,583	1,583	12,192	17
18	Various			1999	147,088		20	7,299	7,299	47,255	18
19	Various			2000	149,982		20	7,501	7,501	41,622	19
20	Various			2001	139,226		20	6,961	6,961	30,894	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		2,544,733	65,250		65,250		456,469	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		30,876	792		882	90	10,880	68
69	Financial Statement Depreciation			124,151			(124,151)		69
70	TOTAL (lines 4 thru 69)		$ 3,203,560	$ 190,193		$ 96,978	$ (93,215)	$ 687,355	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,203,560	$ 190,193		$ 96,978	$ (93,215)	$ 687,355	1
2	Carpeting	2002	15,541		20	2,220	2,220	8,696	2
3	Temperature Control	2002	627		20	63	63	240	3
4	Temperature Switch	2002	560		20	56	56	215	4
5	Monitoring Panel	2002	937		20	94	94	359	5
6	Tiling	2002	963		20	48	48	181	6
7	Wallpaper	2002	8,570		20			8,570	7
8	Wallcovering	2002	1,182		20			1,182	8
9	Ceiling Tile	2002	919		20	46	46	172	9
10	Storage Tank	2002	2,199		20	220	220	825	10
11	Kitchen Lights	2002	1,124		20	112	112	412	11
12	Cove Base	2002	728		20	73	73	267	12
13	Wall Mount Cooler	2002	530		20	53	53	190	13
14	Smoke Detector	2002	1,872		20	187	187	655	14
15	Doors	2002	1,289		20	64	64	215	15
16	Lighting	2002	352		20	35	35	117	16
17	Lighting	2002	517		20	52	52	172	17
18	Roofing	2002	4,265		20	427	427	1,457	18
19	Wall Heaters & A/C	2002	5,259		20	526	526	1,753	19
20	Light Fixtures	2002	1,132		20	113	113	349	20
21	Heating	2002	588		20	59	59	206	21
22	Fire Alarm System	2002	730		20	104	104	408	22
23	Alarm System Repair	2002	563		20	80	80	302	23
24	Alarm System Repair	2002	563		20	80	80	302	24
25	Heating	2002	586		20	59	59	205	25
26	Phone System	2002	510		20	51	51	204	26
27	Walk-In Cooler And Condensing Unit	2003	3,589		20	359	359	1,047	27
28	Roof Repairs	2003	2,480		20	248	248	682	28
29	Custom Built-In Wardrobe Dresser Units	2003	63,420		20	6,342	6,342	16,384	29
30	Elevator Handrails, Window Treatments & Curtains	2003	6,476		20	648	648	1,619	30
31	Sealcoating Parking Lot	2003	2,250		20	225	225	525	31
32	Hot Water System	2003	1,387		20	139	139	312	32
33	Elevator Work	2004	11,800		20	1,180	1,180	2,360	33
34	TOTAL (lines 1 thru 33)		$ 3,347,068	$ 190,193		$ 110,941	$ (79,252)	$ 737,938	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,347,068	$ 190,193		$ 110,941	$ (79,252)	$ 737,938	1
2	2Nd Floor Bathroom Improvment	2004	2,654		20	265	265	487	2
3	Improvements On Resident Room	2004	4,427		20	443	443	775	3
4	Scalcoating And Striping	2004	2,250		20	225	225	375	4
5	New Dynalock	2004	1,460		20	146	146	231	5
6	Air Conditioner	2004	1,753		20	175	175	234	6
7	Air Conditioner Unit	2004	1,753		20	175	175	351	7
8	Back Door	2004	1,190		20	119	119	238	8
9	Bathroom Remodeling	2004	1,701		20	170	170	326	9
10	Toilet And Supplies	2004	452		20	45	45	83	10
11	Toilets	2004	310		20	31	31	57	11
12	2Nd Floor Bathroom Supplies	2004	260		20	26	26	48	12
13	2Nd Floor Bathroom Supplies	2004	3,817		20	382	382	700	13
14	2Nd Floor Bathroom Supplies	2004	149		20	15	15	27	14
15	2Nd Floor Bathroom Supplies	2004	136		20	14	14	25	15
16	2Nd Floor Bathroom Supplies	2004	809		20	81	81	148	16
17	Tile & Fix Walls In Bathroom	2004	4,050		20	405	405	743	17
18	Roof Repairs	2004	7,375		20	738	738	1,352	18
19	Tile & Fix Walls In Bathrooms	2004	4,275		20	428	428	748	19
20	Fittings And Pipe For Water Main	2004	924		20	92	92	154	20
21	Shed	2004	954		20	95	95	119	21
22	Exit Alarm And Fall Monitor	2004	795		20	80	80	86	22
23	Exit Alarm And Fall Monitor	2004	900		20	90	90	98	23
24	Smoke Detector	2005	1,656		20	237	237	237	24
25	Smoke Detector	2005	280		20	40	40	40	25
26	Sink For Utility Room	2005	1,053		20	176	176	176	26
27	Sprinkler Repair	2005	1,137		20	85	85	85	27
28	Fire Doors And Installation	2005	2,055		20	196	196	196	28
29	Fire Doors And Installation	2005	6,001		20	572	572	572	29
30	Wall Air Condenser	2005	3,630		20	151	151	151	30
31	Alarm System And Remote Keys	2005	1,455		20	87	87	87	31
32	Network Cabling Jack At Office On Main Floor	2005	503		20	17	17	17	32
33	Outside Camera And Digital Key Pad	2005	940		20	45	45	45	33
34	TOTAL (lines 1 thru 33)		$ 3,408,172	$ 190,193		$ 116,787	$ (73,406)	$ 746,949	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,408,172	$ 190,193		$ 116,787	$ (73,406)	$ 746,949	1
2	Airconditioners	2005	1,788		20	179	179	179	2
3	New Roof	2005	2,367		20	39	39	39	3
4	Roof Repairs	2005	1,400		20	23	23	23	4
5	Heating Elements	2005	870		20	15	15	15	5
6	2 Heaters	2005	3,213		20	77	77	77	6
7	Window Treatments	2005	4,540		20	38	38	38	7
8	Air Conditioner	2005	3,630		20	86	86	86	8
9	2 Air Conditioners	2005	3,213		20	38	38	38	9
10	Blinds	2005	1,454		20	12	12	12	10
11									11
12									12
13									13
14									14
15									15
16									16
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,430,647	$ 190,193		$ 117,294	$ (72,899)	$ 747,456	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,430,647	$ 190,193		$ 117,294	$ (72,899)	$ 747,456	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,430,647	$ 190,193		$ 117,294	$ (72,899)	$ 747,456	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,430,647	$ 190,193		$ 117,294	$ (72,899)	$ 747,456	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,430,647	$ 190,193		$ 117,294	$ (72,899)	$ 747,456	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,430,647	$ 190,193		$ 117,294	$ (72,899)	$ 747,456	1
2									2
3									3
4									4
5									5
6									6
7									7
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,430,647	$ 190,193		$ 117,294	$ (72,899)	$ 747,456	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,430,647	$ 190,193		$ 117,294	$ (72,899)	$ 747,456	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,430,647	$ 190,193		$ 117,294	$ (72,899)	$ 747,456	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,430,647	$ 190,193		$ 117,294	$ (72,899)	$ 747,456	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,430,647	$ 190,193		$ 117,294	$ (72,899)	$ 747,456	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,430,647	$ 190,193		$ 117,294	$ (72,899)	$ 747,456	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,430,647	$ 190,193		$ 117,294	$ (72,899)	$ 747,456	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 3,430,647	$ 190,193		$ 117,294	$ (72,899)	$ 747,456	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,430,647	$ 190,193		$ 117,294	$ (72,899)	$ 747,456	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	116		1998	1975	$ 2,544,733	$ 65,250		$ 65,250	$	$ 456,469	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
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12											12
13											13
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28											28
29											29
30											30
31											31
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35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
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65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,544,733	$ 65,250		$ 65,250	$	$ 456,469	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Dynamic		1993	1993	$ 30,876	$ 792		$ 882	$ 90	$ 10,880	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 30,876	$ 792		$ 882	$ 90	$ 10,880	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 897,590	$ 31,170	$ 97,107	$ 65,937	10	$ 733,728	71
72	Current Year Purchases	60,570		16,064	16,064	10	16,064	72
73	Fully Depreciated Assets	52,175				10	52,175	73
74								74
75	TOTALS	$ 1,010,335	$ 31,170	$ 113,171	$ 82,001		$ 801,967	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		BUS	2004	$ 44,500	$	$ 6,357	$ 6,357	5	$ 8,476	76
77		USED VAN	2005	16,080		431	431	5	431	77
78		Dynamic Allocation		12,002	774	808	34	5	4,727	78
79										79
80	TOTALS			$ 72,582	$ 774	$ 7,596	$ 6,822		$ 13,634	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,841,423	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 222,137	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 238,061	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 15,924	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,563,057	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 2,580 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation from Dynamic		$	$ 3,433	17
18					18
19					19
20					20
21	TOTAL		$	$ 3,433	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [X] YES
   - [ ] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [X]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		575		575
8	CNA Competency Tests				
9	TOTALS	$	$ 575	$	$ 575
10	SUM OF line 9, col. 1 and 2 (e)	$ 575			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	$ 68,025		$	$		$ 68,025	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	9,684					9,684	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	69,390		32			69,422	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				166,937		166,937	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					2,098	33,480		35,578	13
14	TOTAL			$ 147,099		$ 2,130	$ 200,417		$ 349,646	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion **#** 0036533 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 235,250	$ 336,618	1
2	Cash-Patient Deposits	42,451	42,451	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	685,041	685,041	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,077	38,077	6
7	Other Prepaid Expenses	8,782	8,782	7
8	Accounts Receivable (owners or related parties)	(30,199)	72,401	8
9	Other(specify): See Attached Schedule	17,615	200	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 997,017	$ 1,183,570	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		327,859	13
14	Buildings, at Historical Cost		2,544,733	14
15	Leasehold Improvements, at Historical Cost	815,719	815,719	15
16	Equipment, at Historical Cost	649,434	1,055,434	16
17	Accumulated Depreciation (book methods)	(809,930)	(1,675,399)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,000	6,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,000)	(6,000)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		9,910	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 655,223	$ 3,078,256	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,652,240	$ 4,261,826	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 174,980	$ 174,980	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	50,221	50,221	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	191,028	191,028	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,704	3,704	31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,000	51,000	32
33	Accrued Interest Payable	444	5,404	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,943	8,943	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	21,000	21,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 501,320	$ 506,280	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	101,213	101,213	39
40	Mortgage Payable		1,258,156	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 101,213	$ 1,359,369	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 602,533	$ 1,865,649	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,049,707	$ 2,396,177	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,652,240	$ 4,261,826	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 968,664	1
2	Restatements (describe):		2
3	**Rounding Adj.**	3	3
4	**Depreciation Adjustment**	(1,495)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 967,172	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	152,135	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(69,600)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 82,535	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,049,707	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,521,007	1
2	Discounts and Allowances for all Levels	(1,146,370)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,374,637	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	857,800	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 857,800	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	248,482	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	31,220	19
20	Radiology and X-Ray	5,042	20
21	Other Medical Services	23,423	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 308,167	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,656	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,656	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	491	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 491	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,545,751	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	816,914	31
32	Health Care	1,544,529	32
33	General Administration	941,882	33
	B. Capital Expense		
34	Ownership	656,623	34
	C. Ancillary Expense		
35	Special Cost Centers	370,158	35
36	Provider Participation Fee	63,510	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,393,616	40
41	**Income before Income Taxes (line 30 minus line 40)****	152,135	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 152,135	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,945	2,086	$ 54,485	$ 26.12	1
2	Assistant Director of Nursing	2,027	2,223	58,095	26.13	2
3	Registered Nurses	7,204	7,782	190,262	24.45	3
4	Licensed Practical Nurses	16,018	17,864	407,472	22.81	4
5	CNAs & Orderlies	50,933	52,898	638,241	12.07	5
6	CNA Trainees					6
7	Licensed Therapist	4,128	4,485	147,099	32.80	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,916	2,125	29,793	14.02	9
10	Activity Assistants	4,239	4,402	29,470	6.69	10
11	Social Service Workers			43,625		11
12	Dietician					12
13	Food Service Supervisor	1,780	2,014	32,168	15.97	13
14	Head Cook	4,270	4,553	51,408	11.29	14
15	Cook Helpers/Assistants	12,961	13,618	100,994	7.42	15
16	Dishwashers					16
17	Maintenance Workers	4,895	5,225	75,160	14.38	17
18	Housekeepers	6,082	6,558	46,001	7.01	18
19	Laundry	4,097	4,477	28,322	6.33	19
20	Administrator	1,737	2,085	63,225	30.32	20
21	Assistant Administrator					21
22	Other Administrative			18,000		22
23	Office Manager					23
24	Clerical	6,569	6,974	18,255	2.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,714	1,714	19,349	11.29	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	842	842	20,512	24.36	33
34	TOTAL (lines 1 - 33)	133,357	141,925	$ 2,071,936 *	$ 14.60	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	245	$ 7,824	01-03	35
36	Medical Director	24	1,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	146	5,820	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	64	3,072	11-03	44
45	Social Service Consultant	44	2,530	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	523	$ 20,446		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	13	$ 440	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	531	12,044	10-03	52
53	TOTAL (lines 50 - 52)	544	$ 12,484		53

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pam Ingold	Administrator	0	$ 63,225
Fred Aaron	Administration	13.1	17,000
Diana Magafas	Administration	.56	1,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 81,225

B. Administrative - Other

Description	Amount
Management Fees-Dynamic Healthcare	$ 41,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 41,000

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 13,903
Health Data Systems	Data Processing	4,118
Legal See Attached	Legal Fees	67,238
Allocation Dynamic	Bookkeeping Svc	248,400
Personnel Planners	Unemployment Consult	1,095
Econocare	Purchasing	696
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 335,450

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,265
Unemployment Compensation Insurance	38,398
FICA Taxes	154,378
Employee Health Insurance	26,751
Employee Meals	19,163
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	10,310
TOTAL (agree to Schedule V, line 22, col.8)	$ 307,265

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,790
Health Care Worker Background Check	10
(Indicate # of checks performed 1)	
Licenses & Permits	3,214
Advertising & Promotion	60,145
Dues & Subscriptions	4,599
Allocation from Dynamic Consultants	586
Less: Public Relations Expense	( )
Non-allowable advertising	(60,145)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,199

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,585
Allocation from Dynamic Consultants	64
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,649

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Willow Crest Nursing Pavilion # 0036533 Report Period Beginning: 01/01/05 Ending: 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. **Illinois Council on Long Term Care $7150**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **755** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **63,510**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **19,163** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.